CHAPTER 3

MEDICARE REIMBURSEMENT

This chapter discusses how to receive reimbursement from the Medicare Program.

Medicare Claims

A claim is defined as a filing from a provider, supplier, or beneficiary that includes a request for Medicare payment and furnishes the Medicare Contractor with sufficient information to determine whether payment of benefits is due and the amount of payment.

Providers and suppliers who furnish covered services to Medicare patients on or after September 1, 1990 are required to submit claims for their services and cannot charge beneficiaries for completing or filing a Medicare claim. Medicare Contactors monitor compliance with these requirements. Offenders may be subject to a Civil Monetary Penalty of up to $10,000 for each violation.

Exceptions to Mandatory Filing

Providers and suppliers are not required to file claims on behalf of Medicare beneficiaries when:

- The claim is for services for which Medicare is the secondary payer, the primary insurer's payment is made directly to the beneficiary, and the beneficiary has not furnished the primary payment information needed to submit the Medicare secondary claim;
- The claim is for services furnished outside the U.S.;
- The claim is for services initially paid by third-party insurers who then file Medicare claims to recoup what Medicare pays as the primary insurer (e.g., indirect payment provisions);
- The claim is for other unusual services, which are evaluated by Medicare Contractors on a case-by-case basis;
- The claim is for excluded services (some supplemental insurers who pay for these services may require a Medicare claims denial notice prior to making payment);
- He or she has opted out of the Medicare Program by signing a private contract with the beneficiary; or
- He or she has been excluded or debarred from the Medicare Program.

In general, Medicare fee-for-service claims must be filed timely, which means that they must be filed on or before December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year are considered furnished in the following year.

The chart below illustrates the timeframes for claims submission to Medicare.

FILING TIME LIMITS	
Claims With Dates Of Service	**Must Be Submitted By**
October 1, 2001 – September 30, 2002	December 31, 2003
October 1, 2002 – September 30, 2003	December 31, 2004
October 1, 2003 – September 30, 2004	December 31, 2005
October 1, 2004 – September 30, 2005	December 31, 2006
October 1, 2005 – September 30, 2006	December 31, 2007

Electronic Claims

All providers and suppliers, with the exception of those listed in the Paper Claims Section below, must submit claims electronically via Electronic Data Interchange (EDI) in the Health Insurance Portability and Accountability Act (HIPAA) format. Each provider or supplier must complete a Centers for Medicare & Medicaid Services (CMS) Standard EDI Enrollment Form and send it to the Medicare Contractor prior to submitting electronic media claims (EMC). A sender number, which is required in order to submit electronic claims, will then be issued. An organization that is comprised of multiple components that have been assigned Medicare legacy identifiers may elect to execute a single EDI Enrollment Form on behalf of the organizational components to which these numbers have been assigned. The EDI Enrollment Form can be found in the Medicare Claims Processing Manual (Pub. 100-04) located at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

Electronic Media Claims Submissions

Claims are electronically transmitted to the Medicare Contractor's system, which verifies claim data. This information is then electronically checked or edited for required information. Claims that pass these initial edits, also called front-end or pre-edits, are processed in the claims processing system according to Medicare policies and guidelines. Claims with inadequate or incorrect information may be:

- Returned to the provider or supplier for correction;
- Suspended in the Contractor's system for correction; or
- Have information corrected by the system (in some cases).

A confirmation or acknowledgment report, which indicates the number of claims accepted and the total dollar amount transmitted, is generated to the provider or supplier. This report also indicates the claims that have been rejected and reason(s) for the rejection. The advantages of EMC submission include:

- Correctly filed claims can be paid 14 days after receipt, compared to the 29 days after receipt for payment of paper claims (effective January 1, 2006, the waiting period for payment of paper claims was extended);
- Elimination of mailroom processing; and
- Payment Contractor systems may provide notification of critical claim filing errors so that claims can be corrected before they enter the Medicare claims processing system.

Electronic Media Claims Submission Alternatives

Providers and suppliers who do not submit electronic claims using EMC may choose to alternatively submit claims:

- Through a software vendor, clearinghouse, or billing agent; or
- Using Medicare's free billing software.

Electronic versions of CMS claim forms can be found at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website.

Paper Claims

For claims received on or after October 16, 2003, only the following providers and suppliers may submit paper claims, as mandated by HIPAA:

- Small Part A providers and suppliers who have fewer than 25 full-time equivalent employees;
- Providers and suppliers who have fewer than 10 full-time equivalent employees;
- Dentists;
- Participants in Medicare demonstration projects who require paper claim filing due to inability of the applicable Implementation Guide to report data essential for the demonstration;
- Providers and suppliers who conduct mass immunizations (e.g., flu injections) may submit paper roster claims;
- Providers and suppliers who submit claims when more than one other payer is responsible for payment prior to Medicare payment;
- Providers and suppliers who only furnish services outside the U.S.;
- Providers and suppliers who experience a disruption in electricity and communication connection that is beyond their control; and
- Providers and suppliers who can establish "unusual circumstances" that preclude submission of claims electronically.

Non-institutional providers and suppliers use the CMS-1500 claim form to bill Medicare Contractors and Durable Medical Equipment (DME) Medicare Administrative Contractors (MAC). CMS-1500 claim forms can be ordered from:

- U.S. Government Printing Office
  http://bookstore.gpo.gov
  Telephone: (866) 512-1800;
- Printing companies; and
- Office supply stores.

Institutional providers and suppliers use the CMS-1450, also known as UB-92, to bill Medicare Contractors. UB-92 claim forms can be ordered from:

National Uniform Billing Committee
www.nubc.org/guide.html
Telephone: (800) 242-2626

Effective May 23, 2007, a National Provider Identifier must be included on claim forms. Since the UB-92 does not have a field to report an NPI, it is being updated and replaced with the UB-04 claim form. CMS expects to discontinue acceptance of UB-92 forms effective May 23, 2007.

Durable Medical Equipment, Prosthetics and Orthotics, and Parenteral and Enteral Nutrition Claims

DME MACs have jurisdiction for following claims:

- Nonimplantable DME, prosthetics, orthotics, and supplies (including items for home use);
- Parenteral and enteral nutrition (PEN) products (other than items furnished to inpatients covered under Part A);
- Certain oral drugs billed by pharmacies; and
- Method II home dialysis.

Deductibles, Coinsurance, and Copayments

Providers and suppliers must collect unmet deductibles, coinsurance, and copayments from the beneficiary. The deductible is the amount the beneficiary must pay for health care before Medicare begins to pay, either for each benefit period for Part A or each year for Part B. These amounts can change every year. Coinsurance is the percent of the Medicare-approved amount that the beneficiary pays after he or she pays the plan deductible. In some Medicare plans, fixed amounts called copayments are paid by the beneficiary for each medical service. If a beneficiary is unable to pay these charges, he or she should sign a waiver that explains the financial hardship. If a waiver is not assigned, the beneficiary's medical record should reflect normal and reasonable attempts to collect the

charges before they are written off. The same attempts to collect charges must be applied to both Medicare beneficiaries and non-Medicare beneficiaries. Consistently waiving deductibles, coinsurance, and copayments may be interpreted as program abuse.

On assigned claims, the beneficiary is responsible for:

- Unmet deductibles;
- Applicable coinsurance and copayments; and
- Charges for services and supplies that are not covered by Medicare.

Coordination of Benefits

Coordination of Benefits (COB) is the process that determines the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim. The COB Contractor completes activities that support the collection, management, and reporting of beneficiaries' other health care coverage that is primary to Medicare. The COB Contractor also has responsibility for consolidation of the claims crossover process, which ensures that all supplemental payers have the opportunity to receive Medicare processed claims from one source.

The table below describes some of the ways that the COB Contractor determines whether beneficiaries have other health care coverage that is primary to Medicare.

Determining Other Health Care Coverage

METHOD	DESCRIPTION
Initial Enrollment Questionnaire	Questionnaire that is sent to Medicare beneficiaries approximately three months before Medicare coverage begins regarding their other health insurance coverage
Internal Revenue Service, Social Security Administration, and Centers for Medicare & Medicaid Services Data Match	Questionnaire completed by employers regarding Group Health Plan coverage for identified workers who are either entitled to Medicare or are married to a Medicare beneficiary
Medicare Secondary Payer Claims Investigation	Collection of data regarding health insurance coverage that may be primary to Medicare based on information submitted on a medical claim or from other sources
Voluntary Medicare Secondary Payer Data Match Agreements	Agreements that allow for electronic data exchange of Group Health Plan eligibility and Medicare information between the Centers for Medicare & Medicaid Services and employers or insurers

Medicare Secondary Payer Program

Medicare law requires that providers and suppliers determine whether Medicare is the primary or secondary payer prior to submitting a claim. In addition, primary payers must be identified on claims submitted to Medicare. Providers and suppliers are required to ask beneficiaries or their representatives about other insurance for every admission, outpatient encounter, or start of care. The following secondary payer information can be found via the Medicare Secondary Payer (MSP) Auxiliary File in the Common Working File (CWF):

- MSP effective date;
- MSP termination date;
- Patient relationship;
- Subscriber name;
- Subscriber policy number;
- Insurer type;
- Insurer information (name, group number, address, city, state, and ZIP code);
- MSP type;
- Remarks code;
- Employer information (name, address, city, state, and ZIP code); and
- Employee information (identification number).

Providers and suppliers can have access to the CWF through a connection with their local Medicare Contractor. However, they should not rely on CWF information alone. Since MSP circumstances change quickly and CWF information may not be accurate, providers and suppliers should verify other health insurance information with the patient.

The benefits of the MSP Program include:

- Saves the Medicare Program over 4 billion dollars annually;
- Providers and suppliers who bill plans that are primary to Medicare may receive payment up to submitted charges. In many instances, plans that are primary pay more than the amount allowed under the Medicare Program; and
- Limits the beneficiary's out-of-pocket expenses.

The chart below depicts common situations when Medicare may pay first or second.

Common Situations When Medicare May Pay First or Second

If The Beneficiary	And This Condition Exists	Then This Program Pays First	And This Program Pays Second
Is age 65 or older and is covered by a Group Health Plan (GHP) through current employment or a spouse's current employment →	The employer has fewer than 20 employees →	**Medicare →**	GHP
	The employer has 20 or more employees or at least one employer is a multi-employer group that employs 20 or more individuals →	GHP →	**Medicare**
Has an employer retirement plan and is age 65 or older or is disabled and age 65 or younger →	The beneficiary is entitled to Medicare →	**Medicare →**	Retiree Coverage
Is disabled and covered by a Large Group Health Plan (LGHP) through his or her own current employment or through a family member's current employment →	The employer has fewer than 100 employees →	**Medicare →**	LGHP
	The employer has 100 or more employees, or at least one employer is a multi-employer group that employs 100 or more individuals →	LGHP →	**Medicare**
Has End-Stage Renal Disease (ESRD) and GHP coverage →	Is in the first 30 months of eligibility or entitlement to Medicare →	GHP →	**Medicare**
	After 30 months →	**Medicare →**	GHP
Has ESRD and Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage →	Is in the first 30 months of eligibility or entitlement to Medicare →	COBRA →	**Medicare**
	After 30 months →	**Medicare →**	COBRA
Is covered under Workers Compensation (WC) because of a job-related illness or injury →	The beneficiary is entitled to Medicare →	WC →	**Medicare**
Has black lung disease and is covered under the Federal Black Lung Program →	The beneficiary is eligible for the Federal Black Lung Program →	Federal Black Lung Program →	**Medicare**
Has been in an accident and no-fault or liability insurance is involved →	The beneficiary is entitled to Medicare →	No-fault or liability Insurance →	**Medicare**
Is age 65 or older or is disabled and covered by Medicare and COBRA →	The beneficiary is entitled to Medicare →	**Medicare →**	COBRA
Has Veterans Health Administration (VHA) benefits →	Received VHA authorized health care services at a non-VHA facility →	VHA →	**Medicare may pay when the services are Medicare covered services and are not covered by the VHA**

Medicare may make payment if the primary payer denies the claim and the provider or supplier includes documentation that the claim has been denied in the following situations:

- The Group Health Plan (GHP) denies payment for services because the beneficiary is not covered by the health plan;
- The no-fault or liability insurer denies payment or does not pay the bill because benefits have been exhausted;
- The Workers Compensation (WC) Plan denies payment (e.g., when it is not required to pay for certain medical conditions);
- The Federal Black Lung Program does not pay the bill;
- Benefits under the plan are exhausted for particular services;
- The services are not covered under the plan;
- A deductible applies; or
- The beneficiary is not entitled to benefits.

In liability, no-fault, or WC situations, Medicare may make a conditional payment for covered Medicare services in order to prevent beneficiary financial hardship when:

- The claim is not expected to be paid promptly within the specified time period for any reason except when the plan claims that its benefits are secondary to Medicare;
- The properly submitted claim was denied in whole or in part;
- Due to the physical or mental incapacity of the beneficiary, a proper claim was not filed with the primary insurer; or
- The beneficiary or provider/supplier who has accepted assignment filed a proper claim in whole or in part based on an assertion other than that the GHP or Large Group Health Plan is the secondary payer to Medicare.

When conditional payments are made under these situations, they are made on the condition that both the insurer and the beneficiary will reimburse Medicare to the extent that payment is subsequently made by the insurer.

Medicare Contractors process claims submitted for primary or secondary payment and can answer the following questions:

- Billing;
- Recovery; and
- Claim or service denials and adjustments.

The COB Contractor should be contacted regarding all other MSP inquiries at:

General written inquiries:
MEDICARE - Coordination of Benefits
P.O. Box 5041
New York, NY 10274-5041
Telephone: (800) 999-1118

Questionnaires and correspondence:
MEDICARE - COB
Data Match Project
P.O. Box 125
New York, NY 10274-0125

MEDICARE - COB
MSP Claims Investigation Project
P.O. Box 5041
New York, NY 10274-5041

MEDICARE - COB
Voluntary Agreement Project
P.O. Box 660
New York, NY 10274-0660

MEDICARE - COB
Initial Enrollment Questionnaire Project
P.O. Box 17521
Baltimore, MD 21203-7521

If Medicare processes and mistakenly makes primary payment and the provider or supplier receives primary payment from an insurance plan that is primary to Medicare, he or she must refund the payment to the Contractor.

To find additional information about MSP, see the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-1) and the Medicare Secondary Payer Manual (Pub. 100-5) at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

Incentive and Bonus Payments

Health Professional Shortage Area Incentive Payment

Effective January 1, 1991, under §1833(m) of the Social Security Act, Health Professional Shortage Area (HPSA) incentive payments will be paid to physicians who furnish medical care in geographic areas that have been designated as primary medical care HPSAs by the Health Resources and Services Administration (HRSA).

Under §413 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, beginning on January 1, 2005 HPSA incentive payments will be paid automatically for services furnished in full county primary care geographic area HPSAs and mental health HPSAs. Physicians will no longer need to identify that their services are furnished in a full county primary care geographic area HPSA. An automated file of HPSA designations will be updated on an annual basis, effective for services on or after January 1 of each calendar year. Physicians can self-designate throughout the year for newly designated HPSAs and HPSAs not included in the automated file based on the date of the data run used to create the file.

Psychiatrists who furnish services in mental health HPSAs with dates of service on or after January 1, 2004 are also eligible for the incentive payment. Physicians may be entitled to a 10 percent HPSA incentive payment and/or a 5 percent Physician Scarcity Area (PSA) bonus payment for the same service as long as the area where the service is performed meets both sets of criteria. The HPSA and PSA payments are based on the paid amount of the claim and are paid on a quarterly basis.

The QB modifier for a physician providing a service in a rural HPSA and the QU modifier for a physician providing a service in an urban HPSA must be submitted for the following ZIP code areas that:

- Do not fall within a designated full county HPSA;
- Do not fall within the county based on a determination of dominance made by the U.S. Postal Service;
- Are partially within a partial county HPSA; or
- Are designated after the annual update is made to the automated file.

Effective for claims with dates of service on or after January 1, 2006, the QB and QU modifiers will no longer be accepted. The AQ modifier (Physician providing a service in a Health Professional Shortage Area) will replace the QB and QU modifiers. Claims with prior dates of service must still be submitted with the QB and QU modifiers.

To determine if a modifier is needed, physicians should:

- Visit *www.cms.hhs.gov/HPSAPSAPhysicianBonuses* on the CMS website to find out whether the location where services are furnished is within a HPSA bonus area;
- Visit the U.S. Census Bureau website at *www.Census.gov* or the Federal Financial Institutions Examination Council website at *www.ffiec.gov/default.htm* to determine if the census tract where services are furnished is in an eligible HPSA; and
- Review letters of designation received from HRSA and verify eligibility of their area for a bonus with their Medicare Contractor before submitting services with a HPSA modifier. The letters of designation must be provided as documentation to the Contractor upon request.

To find additional information about HPSAs, visit *www.cms.hhs.gov/HPSAPSAPhysicianBonuses* and Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) located at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

Physician Scarcity Area Bonus Payment

The MMA provided a five percent incentive payment to physicians furnishing services in PSAs. As of January 1, 2005, Medicare pays primary care physicians who furnish services in a primary care scarcity county and specialty physicians who furnish services in a specialist care scarcity county an additional amount equal to five percent of the amount paid for their professional services under the Medicare Physician Fee Schedule. The Congress created the new incentive payment program to make it easier to recruit and retain both primary and specialist care physicians for furnishing services to Medicare beneficiaries in PSAs. A PSA is a U.S. county with a low ratio of primary care or specialty physicians to Medicare beneficiaries.

A primary care physician is defined as a:

- General practitioner;
- Family practice practitioner;
- General internist;
- Obstetrician; or
- Gynecologist.

A specialty care physician is defined as other than a primary care physician.

The following providers are not eligible for the specialty physician PSA bonus payment:

- Dentists;
- Chiropractors;
- Optometrists; and
- Podiatrists.

Section 413 of the MMA states that for physician professional services furnished on or after January 1, 2005 and before January 1, 2008, a PSA bonus payment will be available as follows:

- A 5 percent bonus payment (equal to 5 percent of the payment amount for the services furnished) will be available to primary and specialty physicians in counties (primary care or specialist care scarcity counties) with the lowest 20 percent ratio of primary care or specialty care physicians to Medicare eligible individuals residing in the county.
- To the extent that it is feasible, a rural census tract of a Metropolitan Statistical Area will be treated as an equivalent area for the purpose of qualifying as a primary care or specialist care scarcity county.
- The same services may qualify as a HPSA incentive payment and PSA bonus payment, resulting in a physician receiving a total 15 percent bonus payment as long as the area where the service is performed meets both sets of criteria.
- Determination of the bonus payment is made based on the ZIP code where the service was furnished. To find information about ZIP codes where automatic PSA payments will be made, visit *www.cms.hhs.gov/HPSAPSAPhysicianBonuses* on the CMS website.
- Bonus payments are made on a quarterly basis.
- The technical component of diagnostic services and services that are fully technical are not eligible for the bonus payment.

In some cases, a service may be furnished in a county that is considered a PSA, but the ZIP code is not considered dominant for that area. The bonus cannot be made automatically. In order to receive the bonus payment for these areas, physicians must include the AR modifier (Physician providing service in a Physician Scarcity Area) on the claim.

In order to be considered for the bonus payment, the name, address, and ZIP code of where the service was furnished must be included on all electronic and paper claim submissions.

To find additional information about PSAs, visit *www.cms.hhs.gov/HPSAPSAPhysicianBonuses* and Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) located at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

Medicare Notices

Advance Beneficiary Notice

An Advance Beneficiary Notice (ABN) is a written notice that a provider or supplier gives to a beneficiary before items or services are furnished to advise him or her that specified items or services may not be covered by Medicare. Providing an ABN allows the beneficiary to make an informed decision about whether to receive the item or service in question. In general, if a provider or supplier does not provide the beneficiary with an ABN, he or she cannot hold the beneficiary financially liable for the items or services if Medicare payment is denied or reduced. If the provider or supplier properly notifies the beneficiary that the items or services may not be covered, he or she may seek payment from the beneficiary. Providers and suppliers who furnish items or services to the beneficiary based on the referral or order of another provider or supplier are responsible for notifying the beneficiary that the services may not be covered by Medicare and that they can be held financially liable for the items or services if payment is denied or reduced. A copy of the ABN should be kept in the beneficiary's medical record. ABN forms can be found at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website.

Certificate of Medical Necessity

A Certificate of Medicare Necessity (CMN) is included with claims for certain items that require additional information (e.g., DME and PEN). CMN forms can be found at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website.

Notice of Exclusions from Medicare Benefits

The Notice of Exclusions from Medicare Benefits (NEMB) may be used to advise the beneficiary in advance that Medicare will not pay for certain items and services that do not meet the definition of a Medicare benefit or are specifically excluded by law. Providing a NEMB allows the beneficiary to make an informed decision about whether to receive items or services that he or she must pay for or that other health insurance may pay for. Providers and suppliers may use CMS NEMB forms, notices of their own design, or notices developed by professional associations. CMS NEMB forms can be found on at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website.

Remittance Advice

A Remittance Advice (RA) is a notice of payments and adjustments that is sent to the provider, supplier, or biller. After a claim has been received and processed, the Medicare Contractor produces a RA which may serve as a companion to claim payments or as an explanation when there is no payment. The RA explains reimbursement decisions, including the reasons for payments and adjustments of processed claims. The RA features valid HIPAA codes and specific values that make up the claim payment. Some of these codes may identify adjustments, which refer to any changes that relate to how a claim is paid differently from the original billing. There are seven general types of adjustments:

- Denied claim;
- Zero payment;
- Partial payment;
- Reduced payment;
- Penalty applied;
- Additional payment; and
- Supplemental payment.

Medicare Summary Notice

Beneficiaries receive the Medicare Summary Notice (MSN), which lists all services or supplies that were billed to Medicare, on a monthly basis. The MSN replaces the Explanation of Your Medicare Part B Benefits, Medicare Benefit Notice (Part A), Explanation of Medicare Benefits (Part A), Notices of Utilization, and Benefit Denial letters. If a beneficiary disagrees with a claims decision, he or she has the right to file an appeal. See Chapter 7 for more information about appeals. To find information about the beneficiary notices initiative, visit *www.cms.hhs.gov/BNI* on the CMS website.

Other Health Insurance Plans

Medicare Advantage

Providers and suppliers that furnish services to a Medicare beneficiary who is enrolled in a Medicare Advantage (MA) Plan and do not have a contract with the MA Plan to furnish the services should bill the MA Plan. Prior to furnishing services to a MA Plan beneficiary under these circumstances, providers and suppliers should notify the beneficiary that he or she may be responsible for all charges for the health care services furnished.

Medicaid

Medicaid is a cooperative venture funded by Federal and State governments that pays for medical assistance for certain individuals and families with low incomes and limited resources. Within broad national guidelines established by Federal statutes, regulations, and policies, each state:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services;
- Sets the rate of payment for services; and
- Administers its own program.

The following Medicare premium and cost-sharing payment assistance may be available through the State Medicaid Program:

- Payment of Medicare Part A and Part B premiums, deductibles, coinsurance, and copayments for Qualified Medicare Beneficiaries (QMB) who:
    - Have resources that are at or below twice the standard allowed under the Social Security Income Program
    - Have incomes that are at or below 100 percent of the Federal poverty level (FPL) (payments are subject to limits that states may impose on payment rates)
- Payment of Part B premiums for Specified Low-Income Medicare Beneficiaries who:
    - Have resources similar to QMBs (as described above)
    - Have incomes that are below 120 percent of the FPL
- Payment of Part A premiums for Qualified Disabled and Working Individuals (QDWI) who:
    - Previously qualified for Medicare due to disability but lost entitlement because of their return to work (despite the disability)
    - Have incomes that are below 200 percent of the FPL
    - Do not meet any other Medicaid assistance category

QDWIs who do not meet these income guidelines may purchase Medicare Part A and Part B coverage.

Medicare covered services are paid first by the Medicare Program since Medicaid is always the payer of last resort.

Medigap

Medigap is a health insurance policy sold by private insurance companies to fill gaps in Original Medicare Plan coverage. Beneficiaries must be enrolled in Part A and Part B in order to purchase a Medigap policy and, under certain

circumstances, are guaranteed the right to buy a policy. Beneficiaries may authorize a reassignment of benefits on a claim-by-claim basis for participating providers and suppliers to file a claim for reimbursement of Medicare services and coinsurance amounts.

Railroad Retirement

Some Medicare beneficiaries who are retired railroad workers have supplementary medical insurance benefits from the Railroad Retirement Board (RRB). Paper RRB claims should be sent to:

Palmetto GBA
Railroad Medicare
P. O. Box 10066
Augusta, GA 30999

For information regarding electronic claims processing of RRB claims, call (866) 749-4301.

United Mine Workers of America

Some Medicare beneficiaries are members of the United Mine Workers of America (UMWA), which provides a health insurance plan for retired coal miners, spouses, and dependents. Paper UMWA claims should be sent to:

UMWA Health and Retirement Funds
P. O. Box 389
Ephraim, UT 84627-0631

For information regarding electronic claims processing, contact:

Envoy
Telephone: (800) 215-4730

Documentation

Medicare strives to minimize its documentation requirements for most services and to place no additional paperwork burden on providers and suppliers. Items and services should be documented as close as possible to the time they are furnished since late entries increase the likelihood of inaccuracies and may raise questions regarding the cause of the delay. The provider or supplier is responsible for all claims submitted on his or her behalf. Therefore, he or she should:

- Review coding manuals and Medicare publications to ensure proper code selection;
- Choose billing and revenue codes carefully;
- Ensure that codes are based on medical necessity;
- Ensure that office staff are knowledgeable about billing and coding principles if these responsibilities are delegated to them; and
- Conduct quality checks to ensure agreement with selected codes.

National Correct Coding Initiative

CMS developed the National Correct Coding Initiative (NCCI) to promote correct coding by providers and suppliers and ensure that appropriate payments are made for the services they furnish. NCCI applies to claims that contain more than one procedure that is:

- Performed on the same patient;
- On the same date of service; and
- By the same performing provider or supplier.

The following list provides examples of claim denials due to NCCI edits when one of the services should not have been reported on the claim:

- Two procedures are reported that could not possibly have been reported together. For example, reporting the removal of an organ through both an open incision and via laparoscopy.
- Both female and male specific codes for a single patient, on the same date of service, and by the same performing provider or supplier is reported. For example, reporting a cystourethroscopy, with internal urethrotomy of both a female and a male.
- One or more components of a comprehensive service is reported when a single code is available that describes the complete service. For example, separate codes are individually reported to describe the removal of the uterus, ovaries, and fallopian tubes when a single code describes the removal of the organs.
- Both extensive and limited procedures are reported. For example, reporting that both a deep and a superficial biopsy is performed at the same location.
- Two procedures are reported together for which there is a third separate code that describes the combination of services. For example, right heart catheterization and retrograde left heart catheterization are reported when a separate code describes the combined procedures.

The *National Correct Coding Policy Manual in Comprehensive Code Sequence for Part B Medicare Carriers* is available from the National Technical Information Service (NTIS) at:

NTIS Subscriptions Department
5285 Port Royal Road
Springfield, VA 22161
www.ntis.gov/help/subscriptions.asp
Telephone: (800) 363-2068

Providers and suppliers who disagree with an edit should contact:

Correct Coding Initiative
AdminaStar Federal, Inc.
P. O. Box 50469
Indianapolis, IN 46250-0469
Telephone: (317) 841-4600

For additional information about NCCI edits, visit *www.cms.hhs.gov/NationalCorrectCodInitEd* on the CMS website.

Comprehensive Error Rate Testing Program

The purpose of Comprehensive Error Rate Testing (CERT) Program is to measure and improve the quality and accuracy of Medicare claims submission, processing, and payment. Over 140,000 randomly-selected claims are reviewed each year in order to characterize and quantify local, regional, and national error rate patterns. The CERT Contractor may request additional information related to a claim (e.g., medical records or a CMN). This documentation is used to verify that the claim complies with coverage, billing, and coding rules and that the claim was processed correctly by the Medicare Contractor. If the requested information is not received within 90 days, CERT operations will assume that the services were not furnished and the claim submission will be registered as erroneous. To find additional information about CERT, visit *www.cms.hhs.gov/CERT* on the CMS website.

To find additional information about Medicare reimbursement, see the Medicare Claims Processing Manual (Pub. 100-4) located at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.